



ALLERGY QUESTIONNAIRE

Patient Name: _____

Date: _____

Address: _____

Date of Birth: _____

City, State, Zip: _____

Home#: _____

Gender (circle one): MALE FEMALE

Work#: _____

Primary Care Physician: _____

Referring Physician: _____

How were you referred you to our office, if not by your Physician? _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- We do not treat symptoms or diseases.
• Allergy is not a disease, rather a condition.
• A symptom is an attempt by your body to tell you something.
• We will attempt to find the underlying cause.
• We do not use drugs in this program.
• There is no single "healthy" diet that will work for everyone.
• Just because food is considered "healthy", does not mean it is "healthy" for you.
• Your diet consists of everything you eat, drink, rub on your skin, or inhale.
• Our procedures are safe and painless.

Briefly describe the reason for your visit and what you hope to accomplish: _____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

- ___ Infant (Age 0-2) ___ Child (Age 3-5)
___ Child (Age 6-12) ___ Adolescent (Age 13-18)
___ Adult (Age 19-25) ___ Adult (Age 26-40)
___ Adult (Age 41 and over)

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? _____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

PREVIOUS DIAGNOSIS OF ALLERGY

- ___ Yes and allergy shots helped ___ Yes but allergy shots did not help
___ Yes and medication helped ___ Yes but medication did not help
___ None

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU:

Digestive Track

- nausea & vomiting
- diarrhea
- constipation
- bloated feeling
- stomach pains or cramps
- heart burn
- blood and/or mucous in stools

Ears

- itchy ears
- ear aches/ear infections
- drainage from ear
- ringing in ears
- hearing loss
- reddening of ears

Emotions

- mood swings
- anxiety/fear/nervousness
- anger/irritability/aggressiveness
- argumentative
- frustrated/cries easily
- Depression *

Eyes

- watery or itchy eyes
- red/swollen/itchy eyelids
- bags or dark circles under eyes
- blurred or tunnel vision

Head

- headaches
- migraines
- faintness
- dizziness
- insomnia/sleep disorder
- facial flushing

Heart

- Irregular/Skipped Heartbeat *
- Rapid/Pounding Heartbeat*
- Chest Pain *

Joints & Muscles

- pains/aches in joints

- back pain
- neck pain
- disc problems
- arthritis/osteoarthritis
- stiffness/limited movement
- pain/aches in muscles
- feeling weak/tired
- swollen/tender joints
- growing pains in legs
- Psoriatic/Gouty Arthritis *
- Rheumatoid Arthritis *

Lungs

- chest congestion
- bronchitis
- shortness of breath
- difficulty breathing
- persistent cough
- wheezing

Mind

- poor memory
- difficulty completing projects
- difficulty with mathematics
- underachiever
- poor/short attention span
- confusion
- easily distracted
- difficulty making decisions
- mild learning Disabilities

Mouth & Throat Thrush

- chronic coughing
- gagging/clearing throat often
- sore throat/hoarse voice/voice loss
- swollen/discolored tongue/lips
- canker sores
- itching on roof of mouth

Nose

- stuffy nose

- chronically red/inflamed nose
- sinus problems
- hay fever
- sneezing attacks
- excessive mucous formation

Skin

- acne
- itching
- hives/rash/dry skin
- hair loss
- flushing/hot flashes

Weight

- binge eating/drinking
- craving certain foods
- excessive weight
- compulsive eating
- water retention

General

- frequent illness
- frequent/urgent urination
- genital itch/discharge
- anal itching

Genitourinary

- kidney problems
- urinary tract
- bladder
- yeast infections
- menstrual irregularity

Other Conditions

- Autism **
- A.D.H.D. *
- A.D.D. *
- Psoriasis *
- Eczema *
- Auto-Immune Disorder *
- Chronic Fatigue *
- Multiple Chemical Sensitivities *
- Asthma *
- Congestive Heart Failure *
- Severe Diabetic *
- Severe Depression *
- Obsessive Compulsive Disorder *

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

- Mother Father
- Brother/Sister Grandparents
- Son/Daughter Spouse
- None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

- Constant/Chronic with little change Present most of the time
- Present part of the time Present rarely
- Prevents some normal activities Considerable interference with normal life
- Slight interference with normal life No interference with normal life

SYMPTOMS ARE WORSE

- Outdoors and better indoors At nighttime
- In the bedroom or when in bed During windy weather
- During wet or damp weather When the weather changes
- During known pollen seasons In certain rooms or buildings
- When exposed to tobacco smoke With yard work, cut grass, leaves, hay or barns
- When sweeping or dusting the house In areas with mold or mildew
- In air conditioning In fields or in the country
- Tobacco smoke bothers me more than anything else

SYMPTOMS ARE BETTER

- After shower or bath In air conditioning
- Indoors During or after physical activity
- After taking antihistamines With allergy shots

What makes you feel better? _____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

- Dogs Cats Rodents (mice, guinea pigs, etc.)
- Horses or Cattle Rabbits Birds or Feathers
- Bees Other _____
- None

FOOD RELATED SYMPTOMS

- Symptoms flare 5-60 minutes after meals Some foods are craved or addictive
- The smell or odor of some foods increases symptoms Some foods cause nasal symptoms
- Some foods cause swelling of the mouth or tongue Some foods cause rashes or hives
- Some foods cause upset stomach or vomiting Some foods cause diarrhea
- Symptoms occur with restaurant salad bars or Asian foods Some foods cause headaches
- Symptoms occur with any regularly eaten food Some foods cause asthma
- Preservatives, additives or food coloring increase symptoms No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

- Eggs
 - Corn
 - Peanut
 - Shellfish
 - Tomato
 - Coffee or Tea
 - None
 - Milk
 - Wheat
 - Pork
 - Orange or other citrus
 - Yeast
 - Other _____
 - Beef
 - Soybean
 - Fish
 - Potato
 - Chocolate
-

CHEMICALS THAT CAUSE SYMPTOMS

- Insecticides & pesticides
- Perfumes & cosmetics
- Stove or furnace emissions
- Chemicals in the workplace
- Newsprint
- None
- Paints & household cleaners
- Gasoline or automobiles exhaust
- The smell of new fabrics or fabric store
- Laundry detergent
- Other: _____

WHEN ARE YOUR SYMPTOMS WORSE

- January
- May
- September
- February
- June
- October
- Year around
- March
- July
- November
- April
- August
- December

MEDICATIONS

Do you take any of the following medications on a regular basis?

- Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc)
- Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc)
- Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc)
- Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc)
- Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)
- Chemotherapy

Please list any medications that you are currently taking: _____

SMOKING

Do you presently smoke? Yes No If yes, average number of cigarettes per day _____

If yes, at what age did you start? _____

Does anyone smoke in your home? Yes No

PREVIOUS ALLERGY EVALUTION

- Have you ever seen an allergist? Yes No
- Have you had allergy skin testing? Yes No
- Did you have any positive reaction? Yes No

If yes, please list positive allergens (include any medications)

Have you ever received allergy injections? Yes No

WORK ENVIRONMENT

What is your occupation? _____

Are you exposed to chemicals or strong odors at work? Yes No

If yes, briefly explain _____

Are your symptoms worse while at work? Yes No

If yes, briefly explain _____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____

ANYTHING ELSE YOU WOULD LIKE TO ASK? _____
